UNIVERSITY ORTHOPAEDIC CLINIC
ORTHOPAEDIC · SPINE · SPORTS MEDICINE

MR# _____
Patient Name _____

Policy 2

SECURE PATIENT PORTAL

To help us set up your secure portal and transmit a summary of today's visit to the portal so that you can view online, we need the following information.

Patient's Email Address (Email must be yours, not a family member) _____

PERMISSION TO CONTACT

I give my permission to UOC to receive communication form UOC, servicers, and the collectors of my accounts through various means including cell, landline, text, email, auto dialer and voicemail and is not an all-inclusive list.

☐ Yes ☐ No Cell # _____

ADVANCE DIRECTIVE

Do you have an advance Directive ☐ Yes ☐ No

Person elected to make decisions for me _____ Relationship to patient _____

RELEASE OF MEDICAL INFORMATION

☐ PLEASE ONLY DISCLOSE INFORMATION TO ME (If you check this box, do not complete the following release of names)

☐ I AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING PERSON(S). This release also covers picking up prescriptions in my absence.

Name	Relationship to Patient	Date
Name	Relationship to Patient	Date
Name	Relationship to Patient	Date
Name	Relationship to Patient	Date

☐ Sensitive Privileged Information: I authorize release of information relating to AIDS or HIV, Psychiatric Care and/or Psychological Assessment, Testing and Treatment for Alcohol and/or Drug Abuse.

This expiration will expire at the end of the calendar year of your signature below unless you specify an earlier termination. You must complete a new authorization each year. Use or disclosure of the PHI will not result in remuneration to UOC. This information is protected under federal law and you have the right to revoke this authorization in writing. Please be advised however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below you recognize that the protected health information used or disclosed pursuant to this authorization is subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on our authorization. You may refuse to sign the authorization. University Orthopaedic Clinic P.C. will not condition treatment, payment, or enrollment in the health plan, or eligibility of benefits on the individual providing authorization for the requested use or disclosure.

Print Name	Signature (for Authorization of All Items on Page)	Date